MUDGEERABA GENERAL PRACTICE

CONSENT FORM…..*Vaccination Clinic*

Surname_____ Given Name_____ Title_____ Date of birth ___/___/___

Consent form for COVID-19 booster dose

About COVID-19 vaccination

People who have a COVID-19 vaccination have a much lower chance of getting sick from the disease called COVID-19. There are several brands of vaccine in use in Australia. They are both effective and safe.

Medical experts have studied COVID-19 vaccines to make sure they are safe. Most side effects are mild. They may start on the day of vaccination and last for around 1-2 days. As with any vaccine or medicine, there may be rare and/or unknown side effects.

You can tell your healthcare provider if you have any side effects like a sore arm, headache, fever, or any other side effect you are worried about.

Vaccination providers record all vaccinations on the Australian Immunisation Register, as required by Australian law. You can view your vaccination record online through your Medicare account; MyGov account or MyHealthRecord account.

How is the information you provide at your appointment used

For information on how your personal details are collected, stored and used visit https://www.health.gov.au/using-our-websites/privacy/privacy-notice-for-covid-19-vaccinations.

On the day you receive your vaccine

Bring with you evidence of your prior COVID vaccinations <u>if you did not have them at Mudgeeraba General Practice</u>

Before you get vaccinated, tell the person giving you the vaccination if you:

- Have any allergies, particularly anaphylaxis (a severe allergic reaction) to a previous dose of a COVID-19 vaccine, to an ingredient of a COVID-19 vaccine, or to other vaccines or medications. An allergy is when you come near or in contact with something and your body reacts to it and you get sick very quickly. This may include things like an itchy rash, your tongue getting bigger, your breathing getting faster, you wheeze or your heart beating faster.
- Are immunocompromised. This means that you have a weakened immune system that may make it harder for you to fight infections and other diseases. Sometimes a disease like diabetes or cancer can cause this or certain medicines or treatments you take, such as medicine for cancer. You can still have a COVID-19 vaccine, but may wish to consider the best timing of vaccination depending on your underlying condition and/or treatment.
- If you have a past history of cerebral venous sinus thrombosis (a type of brain clot) or heparin induced thrombocytopenia (a rare reaction to heparin treatment)

Yes	No	
☐	☐	Have you had an allergic reaction to a previous dose of a COVID-19 vaccine?
☐	☐	Have you had anaphylaxis to another vaccine or medication?
☐	☐	Have you had a serious adverse event, that following expert review was attributed to a previous dose of a COVID-19 vaccine?
☐	☐	Have you ever had mastocytosis which has caused recurrent anaphylaxis?
☐	☐	Do you have a bleeding disorder?
☐	☐	Do you take any medicine to thin your blood (an anticoagulant therapy)?
☐	☐	Do you have a weakened immune system (immunocompromised)?
☐	☐	Have you been sick with a cough, sore throat, fever or are feeling sick in another way?
☐	☐	Have you had a COVID-19 vaccination in the last six months?
☐	☐	Have you had COVID-19 in the last six months?
☐	☐	Have you ever had myocarditis or pericarditis?
☐	☐	Do you currently have, or have you recently had acute rheumatic fever or endocarditis?
☐	☐	Do you have congenital heart disease?
☐	☐	For people under 30 years of age: do you have dilated cardiomyopathy?
☐	☐	Do you have severe heart failure?
☐	☐	Are you a recipient of a heart transplant?

****If you answer 'Yes' to any of these questions, please ensure you <u>book an appointment to discuss with your GP</u>, pre booking an appointment in one of our clinics****

Consent to receive COVID-19 vaccine

☐ I confirm I have received and understood information provided to me on COVID-19 vaccination

☐ I have had a primary COVID-19 vaccination course of at least two doses before

☐ I confirm that none of the conditions above apply, or I have discussed these and/or any other special circumstances with my regular GP at Mudgeeraba General Practice

☐ I agree to receive a COVID-19 booster vaccine

Patient's name:	
Patient's signature:	
Date:	

☐ I am the patient's guardian or substitute decision-maker, and agree to COVID-19 vaccination of the patient named above

Guardian/substitute decision-maker's name:	
Guardian/substitute decision-maker's signature:	
Date:	